

# Cognitive Therapy Today®

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## From the Director

*Judith S. Beck, Ph.D.*

### Cognitive Behavior Therapy For Soldiers

We are pleased to announce a scholarship program for mental health professionals who work with soldiers, veterans, and their families. While we have trained thousands of military and civilian mental health professionals in various training programs since the 1980s, we are now intensifying our efforts to tailor our programs and offer partial scholarships so that many more will develop expertise in delivering evidence-based, state-of-the-art treatment.

The mental health problems of soldiers and veterans are becoming more apparent with each passing week, and the problems are serious, even life-threatening in many cases. Our soldiers are suffering from depression, suicidality, substance abuse, anger, post-traumatic stress disorder, and other psychiatric disorders. They are experiencing difficulty in their marriages, in their family lives, and at work.

We addressed these problems at our most recent three-day intensive training workshop in September 2009, in which we trained 16 mental health professionals from four different VA medical centers and one Air Force Base. The workshop participants attended didactic training sessions, viewed DVDs of therapy sessions, and directly applied what they learned to their own patients through case discussions, completion of conceptualization/treatment planning

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## From the President

*Aaron T. Beck, M.D.*

### Rhoads Lecture

*On September 15, 2009, Dr. Aaron T. Beck was awarded the Eleventh Jonathan E. Rhoads Commemorative Medal from the College of Physicians of Philadelphia, the American Philosophical Society and the University of Pennsylvania Department of Surgery. He is the first psychiatrist to receive this honor. Below is the first part of the lecture he gave, which will continue in upcoming newsletters.*

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Actually, I never planned to create a new system of psychopathology or psychotherapy. The theory and therapy just grew like Topsy. My research findings, clinical observations, theoretical ideas and therapy were so intertwined at the beginning that it is hard to disentangle them. In retrospect, however, it is possible to tease out the various strands and see where they all come together. In my next project, the study of suicide, I was able to be more systematic in my approach.

My early work contained one surprise after another. I was intrigued by the phenomenon of depression because it seemed to contradict all the accepted norms of human nature: the pleasure principle, maternal instinct, and survival instinct.

My first venture into the study of depression was a research project attempting to confirm the prevailing notion of depression as due to

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### COGNITIVE THERAPY WORKSHOPS AT BECK INSTITUTE

- **November 9 - 11, 2009**
- **February 8 - 10, 2010**
- **March 15 - 17, 2010**
- **June 6 - 8, 2010**
- **July 12 - 14, 2010**

**VISIT: [www.beckinstitute.org](http://www.beckinstitute.org) for information about all our training programs.**

Check out our blog.  
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Watch us on Youtube.  
[www.youtube.com/beckinstitute](http://www.youtube.com/beckinstitute)

## Cognitive Behavior Therapy for Soldiers

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Are you a mental health professional working with soldiers, vets, or their families?

You might be eligible to receive a partial scholarship for participation in our Cognitive Therapy Workshop Program at Beck Institute.

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**VISIT:**

[www.CBTforSoldiers.org](http://www.CBTforSoldiers.org)  
[www.SoldierSuicidePrevention.org](http://www.SoldierSuicidePrevention.org)

## CBT for Soldiers— (continued from page 1)

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worksheets, and role-playing. The feedback we received was overwhelmingly positive. More than one participant described their experience as “the best training program” they had ever attended.

The Beck Institute was able to extend a total of \$4,500 in scholarship money for this training event. While this is just a start, we are eager to continue our efforts to further expand this program, train more professionals and help save more lives.

To learn more about the problems our soldiers (and their families) experience during and following deployment, to apply for a training scholarship, and to find out how you might help, please visit [www.soldiersuicideprevention.org](http://www.soldiersuicideprevention.org) or [www.cbtforsoldiers.org](http://www.cbtforsoldiers.org).

## Dr. Aaron T. Beck’s Rhoads Lecture— (continued from page 1)

retroflected hostility. According to this thesis, the patient has unconscious hostility towards a loved object; this is unacceptable – in the terms of the time “ego-alien” – and thus, the hostility is repressed and turned against the self. This formulation seemed to be quite logical, and it could account for various symptoms of depression. For example, the hostility against the self could be manifested by self-criticism, inability to experience pleasure, loss of interest in other people and important goals, and, ultimately, in suicide.

It seemed to me that the best way to find this unconscious hostility, since it was not conscious, by definition, would be to explore the “Royal Road to the Unconscious,” namely dreams. So, I started to collect dreams from depressed and nondepressed patients. Then, in collaboration with a psychology student, Marvin Hurvich, we prepared a manual for detecting hostility in the dreams of depressed patients. Marvin then scored these dreams blindly for the presence of hostility in dreams of both groups. To my surprise and disappointment, the depressed patients showed less hostility than the nondepressed patients. This was difficult to reconcile with my theory. Some of my colleagues said I simply did not go deep enough. Nonetheless, I did not know how much deeper to go. However, we did notice a particular theme in the dreams of the depressed patients. Mainly, they perceived themselves in very negative ways in the dreams, and were subject to negative experiences. Their own self-image was of being defective, defeated, or diseased, and bad things would happen in the action of the

dreams. For example, a patient dreamed of being alone in the desert with nothing to drink. He then came upon a coke machine, put a nickel in, and all he got was fizz – no liquid and no syrup. Another patient, who was going to a formal dance, discovered that both his shoes were for the left foot. Other patients dreamed of being abandoned, rejected, or humiliated. I then hit upon the hypothesis that, perhaps, this negative image and the negative dream experiences were still a manifestation of hostility against the self – a form of masochism. Only sometime later did I arrive at a different formulation. Later, we confirmed these findings in a large sample of hospitalized patients.

Concurrently, of course, I was seeing patients in therapy, and I had my second surprise. A woman in therapy was regaling me with stories of various sexual escapades. At the end of the session, I asked her how she was feeling. She said she was feeling quite anxious and depressed. I then suggested to her that, undoubtedly, the anxiety was due to her unacceptable sexual ideas and experiences coming to the surface, which triggered anxiety and guilt. She responded, “Of course, you are right, Doctor. I can see that.” However, I noticed that she did hesitate a bit when she said this, and I brought that to her attention. She then said, “Well, to tell you the truth, I was thinking throughout the session that I was boring you.” I was surprised that she had never mentioned this. She said, “I always think I am boring you.” More importantly, there had been a stream of self-critical thoughts. On further exploration, her big problem in

**Dr. Aaron T. Beck's Rhoads Lecture—**  
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life was that she felt she was unattractive and boring and self-critical. In order to impress people, she would be melodramatic. It then was obvious to me that there was certain material in the patients' minds that they did not report in the free association. I found that most of these had to do with monitoring these self-critical thoughts, such as "I sound stupid," or "I should try to impress him."

I found that the patients were having a whole stream of thoughts that they were not reporting to me. I noted that the stream largely had to do with self-monitoring, self-evaluations, and self-criticism. Depressed patients, in particular, would attach negative meanings to how they perceived they were doing in therapy, and would have thoughts such as, "I sound stupid," "I'm not getting anywhere," "I don't have any thoughts," etc.

I decided that I was missing

a great deal in the free association and decided that I could get a better idea of what the patients were thinking by sitting them up. I then made my next discovery, which was that depressed patients attached negative meanings to almost any experience. However, they were frequently unaware of the negative meanings, but only of the bad feelings they had. For example, they would have negative thoughts about various experiences, which took forms such as "She doesn't like me," "I look foolish," "I won't be able to do this," "I can't handle this," "I'm all alone," etc. I then discovered that the patients seemed to interpret all experiences through a negative-colored prism – that is, they could only see the dark side of every experience and could not see anything that was positive.

At this point, I was able to put together these two strands: from the dreams and from the verbalizations. It occurred to me that what the patients were reporting in their dreams actually

were a symbolic representation of their beliefs and attitudes in their waking life. Thus, the dreams of being defective or abandoned were also expressed in their statements such as "I'm stupid" and "Nobody cares about me."

I soon discovered that a key factor in the patients' depression was the fact that their beliefs about themselves shaped the excessive or erroneous meanings they attached to their experiences. These errors were represented in what I called a "thinking disorder," in which they would overgeneralize, selectively extract, or greatly maximize or exaggerate problems. Driving these excessive interpretations or misinterpretations was a negative view of themselves, their future, their current experiences, and their past. It was as though they were seeing things through a dark-colored prism, blocking out the positive and seeing only the negative.

*Would your organization like to receive Training in  
Cognitive Behavior Therapy?*

**The Beck Institute for Cognitive Therapy has national and international training programs in Cognitive Therapy for health and mental health professionals and educators at all levels of experience and expertise. In addition to our on-site training programs, we currently provide training for universities, hospitals, community mental health centers, research programs, private practices, health systems, and other professional settings. Our training ranges from half-day workshops to week-long intensive training programs. Webinars, teleconferencing, and Skype trainings may also be available.**

## BOOK REVIEW

**Sokol, L. & Fox, M.G. (2009). *Think Confident, Be Confident: A Four Step Program to Eliminate Doubt and Achieve Lifelong Self-Esteem*. New York: Perigee.**

**Reviewed by Keith Dobson, Ph.D., *University of Calgary***

*Think Confident, Be Confident* by Leslie Sokol and Marci Fox is a patient manual for the identification and elimination of doubt. The book identifies the key cognitive features of doubt, including the sources of doubt, the emotional and behavioral consequences of doubt, and the critical distinction between doubt and realistic concern. Having done so, the book then presents a four-step process to eliminate doubt, including the process of recognizing and labeling doubt, learning how to evaluate doubt from an evidence-based perspective (which also involves learning about both realistic appraisals as well as the cognitive distortions which lead to doubt), learning how to rethink doubtful situations, and taking action to overcome doubt and to reinforce the confidence that comes with such action.

One of the themes in *Think Confident, Be Confident* is that doubt and its associated reactions (such as avoidance, delay, worry) are driven by a series of “rules.” These rules, which reflect core beliefs and repeated action patterns, can be recognized, evaluated, and systematically challenged. As it says in the book, “The best way to test a rule is to break it and examine the consequences,” so the reader is encouraged to adopt the progressive attitude of testing out rules, and purposely finding out which rules are realistic, as opposed to those which are perhaps unnecessary. As a good cognitive therapist knows, even the process of testing out rules in itself reflects a change in attitude, and it is pointed out that experience can lead to other core belief change, which prompts more courageous activity, and so on. Part of confidence is being willing to accept uncertainty, and part is acceptance that sometimes taking action leads to unpleasant outcomes. However, taking action allows a person the chance to step away from being stuck in doubt, and to work towards meaningful life goals.

This book is obviously written by two expert cognitive therapists, who have worked with doubtful patients. The book is delivered with clear prose, which is written at an accessible level for many readers. It is punctuated with many exercises, as well as suggestions for techniques to learn and apply the ideas that are presented. Also, the book is full of clinical vignettes and examples, which help to make it come alive. One of the very nice features of the book is its positive tone; it presents doubt as a problem that can be overcome with appropriate effort and guidance. In the end, I think that this book will help a lot of people with chronic doubts. While there are other books about doubt on the market, are any of them superior to *Think Confident, Be Confident*? I doubt it!

### **Cognitive Therapy: Art or Science?**

**David A. Clark, Ph.D., *University of New Brunswick, Canada***

From its earliest days psychotherapy has been torn by two ostensibly irreconcilable perspectives. On the one hand, psychotherapists whose primary professional responsibilities involve the delivery of mental health services within health care systems have argued for the preeminence of clinical wisdom and experience as a foundation for effective treatment. On the other hand, practitioners and clinical researchers with a strong academic or research affiliation have advocated a system of psychotherapy that is rooted in and informed by empirical science. According to this perspective advances in psychotherapy efficiency and effectiveness are dependent on systematic empirical research on psychotherapy process and outcome as well as psychopathologic research on the etiology and persistence of psychological disorders. At any moment in time, the discussion within psychotherapy swings

between an emphasis on practice and training versus empirical investigation and verification. So, where do we find cognitive therapy within this debate and has the emphasis changed in recent years?

After forty years of research and development, there can be little doubt that cognitive therapy represents a bridge, an amalgamation of both science and practice. There is much in the historical record of cognitive therapy that supports this assertion. Dr. Beck’s personal approach to the development of cognitive therapy has always shown a strong commitment to scientific empiricism as well as a dedication to the acquisition, training, evaluation and certification of psychotherapeutic skills. The latter is clearly evident to members of the Academy of Cognitive Therapy as well as friends and affiliates of the Beck Institute. Dr. Beck is a pioneer of the clinical workshop, setting training

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## AWARDS

Dr. Aaron T. Beck will be awarded the *Lifetime Achievement Award* at the National Nursing Centers Consortium (NNCC) Conference on Nov. 5, 2009 in Philadelphia, PA  
(see [www.nncc.us](http://www.nncc.us) for more info.)

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Dr. Judith S. Beck will be awarded the Academy of Cognitive Therapy's *Aaron T. Beck Award* at the Association for Behavioral & Cognitive Therapies (ABCT) Convention on Nov. 19, 2009 in New York, NY

## SPEAKING ENGAGEMENTS —CHECK WEBSITES FOR MORE INFORMATION

**October 15, 2009 - New York, NY -Visiting Nurse Service of New York. Speaker:** Christine Reilly, Ph.D., R.N.  
**Workshop:** Introduction to Cognitive Therapy and Cognitive Therapy of Depression.

**November 2-4, 2009 - Oklahoma City, OK - Oklahoma Department of Mental Health. Speaker:** Leslie Sokol, Ph.D.  
**Workshop:** Cognitive Therapy for Personality Disorders.

**November 5-7, 2009 - Philadelphia, PA—National Nursing Centers Consortium. Speaker:** Judith S. Beck, Ph.D.  
**Keynote:** Cognitive Behavior Therapy for Weight Loss. **Award Presentation:** Dr. Aaron T. Beck to receive the Lifetime Achievement Award. **Dialogue:** Drs. Aaron and Judith Beck on *Exciting Developments in the Cognitive Therapy World*.  
**Website:** [www.nncc.us](http://www.nncc.us)

**November 7, 2009 - Valley Forge, PA—Pennsylvania Psychiatric Society. Speaker:** Judith S. Beck, Ph.D. **Presentation:** Cognitive Behavioral Therapy for Depressed Suicidal Patients. **Website:** <http://www.papsych.org/>

**November 11-13, 2009 - Berryville, AR - Ozark Guidance Center. Speaker:** Leslie Sokol, Ph.D. **Workshop:** Cognitive Therapy of Depression & Cognitive Therapy of Anxiety Disorders.

**November 19-22, 2009 - New York, NY - Association for Behavioral and Cognitive Therapies Annual Convention. Speaker:** Aaron T. Beck, M.D. **Invited Address:** Aaron T. Beck in Discussion with Steve Hollon and Robert Leahy—An Intimate Look at the Past, Present and Future of Cognitive Therapy and its Founder. **Website:** [www.abct.org](http://www.abct.org)

**December 7-11, 2009 - Hong Kong - Hong Kong Polytechnic Institute of Advanced Nursing Studies. Speaker:** Leslie Sokol, Ph.D. **Workshop:** Intensive Cognitive Behavior Therapy Training.

**December 9-13, 2009 - Anaheim, CA - Sixth Evolution of Psychotherapy Conference. Speaker:** Aaron T. Beck, M.D.  
**Keynote:** Cognitive Behavioral Therapy in the 21st Century. **Speaker:** Judith S. Beck, Ph.D. **Workshops, clinical demonstrations, panel discussions, and invited address:** Cognitive Therapy for Personality Disorders; CBT for Weight Loss and Maintenance; CBT for Depression; Advances in CBT. **Website:** [www.brieftherapyconference.com](http://www.brieftherapyconference.com)

**January 12-14, 2010 - Oklahoma City, OK - Oklahoma Department of Mental Health. Speaker:** Leslie Sokol, Ph.D.  
**Workshop:** Cognitive Therapy for Personality Disorders.

**March 25-28, 2010 -Washington, D.C. - The Psychotherapy Networker. Speaker:** Judith S. Beck, Ph.D. **Workshop:** Cognitive Therapy for Personality Disorders. **Website:** <http://www.psychotherapynetworker.org/>

**March 1-4, 2010 - Oklahoma City, OK - Oklahoma Department of Mental Health. Speaker:** Leslie Sokol, Ph.D.  
**Workshop:** Cognitive Therapy for Personality Disorders.

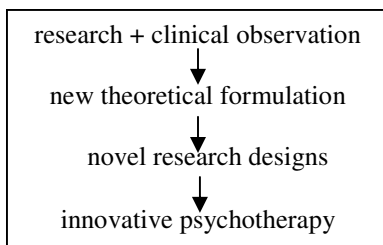
**April 8-18, 2010 - Nairobi, Kenya - Speaker:** Judith S. Beck, Ph.D. **Workshop:** *More information coming.*

**May 7-8, 2010 – Washington, DC - Center for Obesity Research and Education (CORE) Speaker:** Judith S. Beck, Ph.D.  
**Presentation:** Motivating Patients to Change Behaviors. **Website:** <http://www.uchsc.edu/core/index.htm>

## Cognitive Therapy: Art or Science? (continued from page 4)

practices and standards that are now a well-established feature of continuing professional development. However his prodigious contributions and commitment to theory and research in psychopathology and psychotherapy is sometimes overlooked by those confronted with the demands of clinical practice. These contributions should not be lost, as they form the very fabric of what it means to be a cognitive therapist.

While working on *Scientific Foundations of Cognitive Theory and Therapy of Depression* (Clark, Beck & Alford, 1999) I poured over some of Dr. Beck's earliest published and unpublished writings on cognitive theory and therapy. The 1960's represented the dawn of cognitive therapy (e.g., Beck, 1961, 1963, 1964, 1967). Beginning in the psychoanalytic tradition, Beck's early experimentation focused on constructs such as retroflected anger, masochism and the manifest content of dreams. But his findings were not entirely consistent with the psychoanalytic perspective. At the same time Beck describes a "eureka" moment when he observed the presence of negative automatic thoughts in an angry, depressed patient who was undergoing free association (Beck, 1976). This clinical observation coalesced with his laboratory findings, leading to the discovery of faulty information processing as the basis of depression. Together, then, scientific research and clinical observation led to the formulation of a cognitive theory of depression. The progression is clearly documented in the historical record. First there was an articulation of a cognitive theory, followed by a program of research testing key elements of the model (Beck, 1967). Only after empirical verification of the main assumptions of the model do we see a detailed description of cognitive therapy (Beck, Rush, Shaw & Emery, 1979). The progressive development of cognitive therapy is clear;



Today we owe much to the synthesis of science and practice that is evident in cognitive therapy and in the life work of Aaron T. Beck. Cognitive therapy is now a well-established psychotherapy that has brought relief to thousands, if not millions, of people suffering from emotional disorders. The cognitive model has spawned an unprecedented flurry of research activity that has led to enormous advances in our understanding of psychopathology. Without question there is much left to be learned and the cognitive perspective remains a vital heuristic that can guide our advance forward. And yet, cognitive therapy is at a crossroads, its future dependent on further developments and innovation within the next five years. Perennial issues remain such determining the causal status of

cognitive disturbance, demonstrating the incremental effectiveness of cognitive interventions, and improving relapse reduction and prevention.

The future of cognitive therapy and its evolution is really a matter of epistemology. It is my contention that the lessons of history provide a powerful example that the applied science approach (Teasdale & Barnard, 1993) offers the best hope of a bright future for cognitive therapy. A continued commitment to promote, evaluate and incorporate findings from scientific inquiry into clinical practice will lead to a more robust and effective cognitive psychotherapy. At the same time, a greater emphasis on knowledge translation is needed so that research findings are more quickly and accurately adopted into the daily practice of cognitive therapists. But together art and science must be recognized as indispensable to cognitive therapy. Clinical observation and experience sharpens a focus on real-life problems, whereas scientific observation and experimentation provides direction and validation of our therapeutic endeavors. An equal commitment to science and practice is demanding because it requires a breadth of skills and a bifurcated allocation of time and resources that is difficult to achieve. Ultimately the continued vitality of cognitive therapy depends on a cohort of cognitive therapists whose work exemplifies the applied science approach. Today a schism is often apparent between research and practice. Intervention strategies and perspectives are often advanced with little or no empirical basis. The way forward for cognitive therapy is best achieved by reaffirming its roots in scientific empiricism. The great advances in cognitive therapy are attributable to the remarkable synthesis of science and practice seen in the accomplishments of Aaron T. Beck. To the extent that cognitive therapy succeeds in balancing the art of psychotherapy with a commitment to rigorous scientific inquiry, it will continue to provide fresh insights into the alleviation of psychological distress and personal suffering.

### References

- Beck, A.T. (1961). A systematic investigation of depression. *Comprehensive Psychiatry*, 2, 163-170.
- Beck, A.T. (1963). Thinking and depression: 1. Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry*, 9, 324-333.
- Beck, A.T. (1964). Thinking and depression: 2. Theory and therapy. *Archives of General Psychiatry*, 10, 561-571.
- Beck, A.T. (1967). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press.
- Beck, A.T. (1976). *Cognitive therapy of the emotional disorders*. New York: New American Library.
- Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- Clark, D.A., Beck, A.T. (with Alford, B.) (1999). *Scientific foundations of cognitive theory and therapy of depression*. New York: Wiley.
- Teasdale, J.D., & Barnard, P.J. (1993). *Affect, cognition and change: remodelling depressive thought*. Hove, UK: Erlbaum.